Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CYPRESS FAIRBANKS MEDICAL CENT
LAW OFFICES OF P MATTHEW ONEIL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729-7710

Respondent Name
FEDEX FREIGHT EAST INC

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1333-01

MFDR Date Received
December 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Claimant received medically necessary treatment for an emergent condition, specifically relating to an on-the-job injury sustained on 12/22/2010 which resulted in a broken ankle."

Amount in Dispute: $18,758.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was denied because Requestor did not obtain preauthorization approval of the surgery prior to rendition of services. . . . Carrier asserts that the underlying facts do not support that a medical emergency existed on December 29, 2010."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2010	Outpatient Hospital Services	$18,758.27	$6,233.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.600 sets forth rules for prospective and concurrent review of health care.
5. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CX33 – PRE-AUTHORIZATION DENIED
   - FS001 – FEE SCHEDULE REDUCTION - STANDARD

Issues

1. Did the respondent support the insurance carrier's reasons for denial of payment for the disputed services?
2. Did the respondent's position statement raise new denial reasons or defenses?
3. Are the disputed services subject to a contractual agreement between the parties to this dispute?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code CX33 – "PRE-AUTHORIZATION DENIED." 28 Texas Administrative Code §134.600(c), effective May 2, 2006, 31 *Texas Register* 3566; states, in pertinent part, that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services…" §133.2(3)(A) defines a medical emergency as "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." Review of the submitted information finds documentation to support the sudden onset of a medical condition, in this case the discovery of the previously un-diagnosed left ankle fracture, which, in the absence of immediate medical attention, could reasonably be expected to result in serious dysfunction of the patient's ankle or foot. The Division concludes that the occurrence of a medical emergency is supported; therefore, preauthorization was not required. Consequently, the insurance carrier's denial reason is not supported. These services will therefore be reviewed per applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §133.307(d)(2)(B) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR [medical dispute resolution] was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." The respondent's position statement asserts that "even if an emergency did exist so as to excuse the failure to pursue preauthorization, the services performed still would have to pass muster in retrospective review as reasonable and necessary treatment for the compensable injury. The December 30, 2010 utilization review notice indicates that the radiology findings did not support an open reduction and internal fixation under the ODG treatment guidelines." Review of the submitted explanations of benefits finds that the insurance carrier did not deny the services for medical necessity or for reasons related to Division treatment guidelines. Review of the utilization review letter dated December 30, 2010 finds that the letter is addressed to the referring physician, Dr. Jax, not to the health care provider, Cypress Fairbanks Medical Center. No documentation was submitted to support that these newly raised denial reasons or defenses were ever presented to the requestor prior to the date the request for MDR was filed. Therefore, these newly raised defenses or denial reasons shall not be considered in this review.
3. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
4. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
5. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation

and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15. The recommended payment is $15.15.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93. The recommended payment is $13.93.
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.62. 125% of this amount is $7.02. The recommended payment is $7.02.
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.60. 125% of this amount is $10.75. The recommended payment is $10.75.
- Procedure code 74020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.94. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $26.68. The non-labor related portion is 40% of the APC rate or $17.96. The sum of the labor and non-labor related amounts is $44.64. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including any applicable outlier payment, is $44.64. This amount multiplied by 200% yields a MAR of $89.28.
- Procedure code 27792 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0063, which, per OPPS Addendum A, has a payment rate of $3,064.80. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,838.88. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $1,820.86. The non-labor related portion is 40% of the APC rate or $1,225.92. The

sum of the labor and non-labor related amounts is $3,046.78. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.142. This ratio multiplied by the billed charge of $4,935.65 yields a cost of $700.86. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,046.78 divided by the sum of all APC payments is 98.56%. The sum of all packaged costs is $1,768.88. The allocated portion of packaged costs is $1,743.34. This amount added to the service cost yields a total cost of $2,444.20. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including any applicable outlier payment or multiple procedure discount, is $3,046.78. This amount multiplied by 200% yields a MAR of $6,093.56.

- Per Medicare policy, procedure code 99284 is unbundled. This procedure is a component service of procedure code 27792 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2175 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code S0028 represents an item or service for which payment is included in the payment for other services billed on the same date. Separate payment is not recommended.
- Per Medicare policy, procedure code 93005 is unbundled. This procedure is a component service of procedure code 27792 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

6. The total allowable reimbursement for the services in dispute is $6,233.44. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $6,233.44. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,233.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,233.44, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 24, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.